

Responsibility, Research and Reasoning: Nursing through 70 years of the NHS

Introduction

The NHS was created out of the ideal that good healthcare should be available to all, regardless of wealth. When it was launched by the then Minister of Health, Aneurin Bevan, on July 5 1948, it was based on the core principles that it:

- met the needs of everyone
- was free at the point of delivery
- was based on clinical need, not ability to pay

These three principles have guided the development of the NHS over its 70 years and remain at its core (NHS Choices 2015). The laudable aims were particularly important at a time when Britain had been at war for a number of years, resources in the country were limited and significant improvements in available treatments had come about (for example, blood transfusions and antibiotics). Examining the changes of health service delivery since the inception of the NHS offers us the opportunity to consider how nursing has evolved and adapted through the period. This paper draws on our own professional experience (e.g. Rosser 2018), from a fascinating oral history research project we participated in (Thomas & Rosser 2017) and on other notable professional changes that have occurred since the 1940s. It aims to offer some observations and thoughts that may provoke the reader to think about her or his personal practice in the context of wider changes, in order to continue to challenge assumptions and contribute to the growth of the nursing profession.

Nursing in the 1940s

Rivett (1998) highlights that the NHS started at a time when the population was “weary but disciplined by war and accustomed to austerity” and that the poorer members of society had previously gone without medical treatment, relying on traditional but often uncertain home remedies. The NHS now offered the best available care to everyone but what were the implications for nurses?

In a description of a nurse’s personal experience in the 1940s, a picture of the profession as a strict discipline with clear expectations about the relationship with patients was created:

“We learned hospital etiquette: you addressed patients with their title and surname; we had to refer to each other by surname only. It was drilled into us that we were expected to treat people as if they were guests in our home.” (Brown 2008)

In addition to having stringent guidelines about behaviour, nursing in the UK was considered as much more than just employment; it was thought of as a vocation where members were prepared to largely put their personal needs and wants to one side. Student nurses were required to live in the nurses’ home, they undertook regular ‘split shifts’ (7am – 2pm; 5pm – 9pm) and for many years nurses were not permitted to marry (Morrison 2017), having to abandon their careers if they did so.

These restrictions interfered with the ability to live a rounded social life at the time, although this has clearly changed in the past 70 years. In our Memories of Nursing oral history project (Thomas & Rosser 2017), we heard stories from nurses who practised from before the creation of the NHS; they confirmed that they had experienced similar social limitations as well as highlighting a strict hierarchy in hospitals that often affected their status and sphere of influence.

Memories of Nursing: Key Concepts

The aim of the project was to produce rich and detailed accounts of “non-elite nurses who have no record of their lives in historical documents” (Beiderman 2001:61). A group of academics from Bournemouth University was able to access elderly nurses living at the Retired Nurses National Home (RNNH) in Bournemouth, interviewing sixteen participants who had all trained in the UK between 1939 and 1978. The RNNH is a residential home that was established in 1937 at a time when, on retirement, nurses were typically unmarried and were very restricted as to where they could live, having had hospital accommodation throughout their careers and relatively small pensions. The home was created by Miss Fanny Thompson, a matron of a nursing home in Bournemouth who identified the plight of some of her retiring colleagues, and the home was seen as a haven, “a special place that filled a large social void” (Thomas & Richardson 2017). The home has changed over the years as the social needs of nurses have but there is still a predominance of nurses as residents and many of these were very pleased to share their stories with the researchers.

The key concepts that emerged from analysing the data were that of roles and responsibilities (including the hierarchy), compassion and safe practice; these issues are still of prime importance and continue to challenge the nursing profession today.

The researchers (Thomas and Rosser 2017) noted a keen reverence for hierarchy and status, both within nursing and between doctors and nurses. Typical comments included:

“You hardly ever spoke to a doctor. You were just too busy doing all your routine stuff. When the consultant came in, the ward was closed, and you had to tippy toe around. You still had to work, but you mustn’t make any noise at all, you mustn’t drop anything or you were terrified, you know?”

Now, and especially since nursing education entered the hallowed halls of higher education, the focus on interprofessional working has become increasingly important and has helped break down some of the traditional barriers to team working. Working effectively and efficiently in teams across professional groups, with the patient at the heart of the service, has been high on the NHS agenda since the NHS Plan (2000). Whilst there remains some respect for hierarchy, the move to a more equal education preparation has encouraged improved team working across professional groups.

A number of participants in the research emphasised that they were attracted to nursing by the compassion they had witnessed when in hospital themselves or visiting relatives when they were young.

“I know what I want to do—I would love to be a nurse, I would love to do what they are doing.”

Although compassion remains an important aspect of high quality care today, the early 2000s saw a change of direction by the NHS to focus on measurement through quantifiable targets in the interest of efficiency. However this change in emphasis has not always been positive; a report following investigation at the Mid Staffordshire NHS Trust (Francis 2013), as a result of increased morbidity and mortality rates, highlighted the need to refresh compassionate approaches to care alongside the meeting of performance indicators.

Safe practice, with a particular focus on hygiene, was also an important theme in the research and illustrated how committed the participants were to ensure fundamental cleanliness was maintained especially before the widespread use of antibiotics.

“If...by any chance they got a bit of an infection in their wound, well really just about the heavens fell in, it was terrible, it was dreadful.”

Today, patient safety remains high priority alongside the awareness of ‘human factors’ and perhaps, with such a reliance on antibiotics, there is less attention to the fastidious use of hygiene measures. The current prevalence of health care acquired infections that are resistant to antibiotics indicates a need to return to basics, learning from nursing 70 years ago.

Areas of Remarkable Change

In addition to these themes from the Memories of Nursing project, there are other notable changes that are worth considering. These can be grouped under three headings: responsibility, research and reasoning.

Responsibility: The role of the nurse has changed exponentially since the early days of the NHS. In some respects, students shouldered considerable responsibility, being in ‘charge’ of large Nightingale wards while their more senior colleagues would be on break, especially while on night duty. With the introduction of the Diploma in Nursing as the entry requirement to registration in 1989, students became supernumerary, unable to take responsibility for patient care without the supervision of a qualified nurse. Their new education preparation moved from 80% practice: 20% theory to 50:50% theory and practice. The new programme prepared students to be “knowledgeable doers”, able to think critically and challenge existing practice. Qualified nurses’ scope of practice has moved from a task orientation approach at the outset of the NHS to patient centred care. In the early days, nurses had to choose to either follow a management or education pathway if they wished to develop their careers. Now

there are real career pathways available to develop nurses' roles in practice (McSherry et al 2005); new leadership roles have been introduced in the NHS, with consultant and specialist nurses having their own caseloads, able to practice autonomously, diagnose, treat and provide holistic care in ways undreamed of in 1948.

Research: Evidence based practice, now a requirement for all healthcare professionals, was unheard of when the NHS was introduced. Research and nursing had little if any relationship and nurses learned on the job. They followed senior colleagues' examples, did what the doctor ordered (largely without question), used their instincts, learned from their experience and did what they thought was best. Since the introduction of Evidence Based Medicine in the 1980s at McMaster University in Canada, the movement has widened to Evidence Based Practice and was introduced to nursing and the allied health professions in the UK in the 1990s. As nurse education has become more academic, nurses are doing their own research; many are educated to doctoral level particularly at Consultant practitioner level and research underpins much of their practice. Nurses seek to enhance the effectiveness of care by undertaking studies, reflecting on critical incidents and sharing new knowledge through publication and presentation.

Reasoning: Education moved from the earlier training model to an all-graduate entry in 2013, with a balanced approach to the science and art of nursing. From the introduction of the NHS until 1989, student nurses made up the bulk of the nursing workforce in the UK, being paid poorly for their efforts, housed in nurses' homes and being *trained* to do the job. It was not uncommon for students to come off night duty at 8.00am and attend classes or work a shift from 5-9pm that evening. Higher levels of education have increased emphasis on the skills of reasoning/ critical analysis and well-developed professional judgment is an essential requirement of today's nurses. This is increasingly important with current high levels of acuity and complex needs of hospitalised patients and in client caseloads. There were few if any day surgery procedures in the early days of the NHS and patients tended to remain as in-patients for several days. This meant there were various levels of dependency, as patients recovered before going home while others were very ill. This varied dependency assisted the ability to balance nursing workloads. Now, with technological advancement, the patient stay is very much shorter, patients often experience multiple co-morbidities and there exist very complex care scenarios. As such, the day-to-day practice of professional nursing has changed considerably and requires highly skilled, educated and compassionate practitioners who can reason effectively and base care on best available evidence.

Conclusion

The basic concepts of nursing today are the same as they were in 1948 but the context of care delivery, the expectations of the practitioner and the needs of patients bear little resemblance to the scenario at the birth of the NHS. The basic

principles articulated by Bevan remain the bedrock of service in the UK however the future is uncertain with stretched services, expensive diagnostic techniques and therapies, longer lives, complex health needs and increasing levels of patient expectation. To some degree, compared to those interviewed in the Memories of Nursing project, nurses have been liberated, enabled to live full social lives, realise their own potential and contribute to high quality evidence based practice. Rightly, nurses no longer see themselves in a vocation but in a career worthy of attracting the most educationally able in our society and largely want to be able to continue to offer care that meets the needs of all, based on clinical need and not the ability to pay.

Words: 2000

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